BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DAVID A. RUBEN, M.D.** Holder of License No. 11382 For the Practice of Allopathic Medicine In the State of Arizona.	Case Nos. MD-09-0131A MD-09-0250A MD-09-0926A MD-09-1263A MD-10-0100A **ORDER FOR DECREE OF CENSURE, PRACTICE RESTRICTION, PROBATION AND CONSENT TO SAME**

David A. Ruben, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Decree of Censure and Practice Restriction; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board. Respondent consents to the entry of the Order set forth below as a compromise of a disputed matter between Respondent and the Board; and does so only for the purpose of terminating the disputed matter by agreement. While Respondent does not admit the Findings of Fact and Conclusions of law, Respondent acknowledges it is the Board's position that, if this matter proceeded to formal hearing, the Board could establish sufficient evidence to support a conclusion that certain aspects of Respondent's conduct constituted unprofessional conduct.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 11382 for the practice of allopathic medicine in the State of Arizona.

CASE NO. MD-09-0131A

3. The Board initiated case number MD-09-0131A after receiving a complaint regarding Respondent's care and treatment of several patients.

PATIENT AL

4. On November 6, 2006, an eighteen year-old female patient ("AL") presented to Respondent and reported moodiness and irritability. Respondent diagnosed her with Attention Deficit Hyperactivity Disorder (ADHD) and prescribed Adderall; however, there was no documentation of the prescription in AL's record. There also was no documentation that Respondent performed an adequate psychiatric evaluation, which included ordering laboratory studies; obtaining her past medical records, past history of alcohol or substance abuse, or past psychiatric history or performing a functional assessment to support the diagnosis and prescription. There also was no documented initial plan of treatment for AL.

5. From November 2006 through February 2009, Respondent provided AL with frequent, early and escalated doses of Adderall without documenting any rationale for doing so. In addition, on several occasions AL attempted to refill her Adderall prescription early; however, there was no documentation that Respondent investigated or addressed AL's rationale for doing so. During the course of treatment, Respondent added Prozac, Cymbalta, Lorazepam, and Zoloft to AL's medication regime without documenting a rationale for the prescriptions or whether he discussed the risks and benefits of taking the medications. There also was no documentation that Respondent ordered any laboratory studies to support his continued prescribing of Adderall or any urine drug screens to determine whether AL was taking the medication as prescribed and/or any illicit substances. In addition, several of his progress notes were illegible.

6. The standard of care requires a psychiatrist to perform adequate psychiatric evaluations prior to commencing treatment.

7. Respondent deviated from the standard of care because he did not perform an adequate psychiatric evaluation for AL.

8. The standard of care when prescribing Adderall requires a physician to perform tests to confirm the diagnosis and the necessity of the medication and to monitor the patient's use of the medication.

9. Respondent deviated from the standard of care because he did not perform tests to confirm the diagnosis and the necessity of the medication and he did not monitor AL's use of the medication.

10. There was no collateral information to support prescribing Adderall creating a potential for misdiagnosis, addiction, abuse, misuse, overdose, and diversion. Since no urine drug tests were performed it is unknown whether AL was taking the medication as prescribed and/or whether she was utilizing illicit substances.

11. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there was no documentation of the initial Adderall prescription, no documented initial plan of treatment, the psychiatric evaluation was inadequate, there was no documented rationale for his prescribing of several medications, and several of his progress notes were illegible, including the use of non-standard abbreviations.

PATIENT KF

12. On March 25, 2008, a twenty-one year-old female patient ("KF") presented to Respondent and reported difficulty finishing tasks and focusing. Respondent prescribed KF Adderall. There was no documentation that Respondent obtained her past medical records or ordered any laboratory tests that would qualify KF for a diagnosis to support the use of Adderall.

13. At several subsequent office visits, Respondent prescribed frequent early refills of Adderall without documenting any rationale for the prescriptions. On November 4, 2008, Respondent increased KF's dose from 20mg to 30mg without any rationale for the prescriptions. There was no documentation that Respondent ordered any laboratory studies to support his continued prescribing of Adderall or any urine drug screens to determine whether KF was taking the medications as prescribed and/or any illicit substances. In addition, several of Respondent's progress notes were illegible.

14. The standard of care requires a psychiatrist to perform adequate psychiatric evaluations.

15. Respondent deviated from the standard of care because he did not perform an adequate psychiatric evaluation for KF.

16. The standard of care when prescribing Adderall requires a physician to obtain prior medical records, perform tests to confirm the diagnosis and the necessity of the medication and to monitor the patient's use of the medication.

17. Respondent deviated from the standard of care because he did not obtain prior medical records, perform tests to confirm the diagnosis and the necessity of the medication and he did not monitor KF's use of the medication.

18. There was no collateral information to support prescribing Adderall creating a potential for misdiagnosis, addiction, abuse, misuse, overdose, and diversion. Since no

urine drug tests were performed it is unknown whether KF was taking the medication as prescribed and/or whether she was utilizing illicit substances.

19. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did not obtain KF's past medical records, he did not document a physical examination prior to prescribing medications, he did not document any rationale for prescriptions, dosage escalations, and additions of medication and several of his progress notes were illegible, including the use of non-standard abbreviations.

PATIENT JF

20. On August 31, 2007, a nineteen year-old female patient ("JF") was evaluated by Respondent for chronic pain, Attention Deficit Disorder, and Obsessive Compulsive Disorder. JF reported current prescriptions of 40mg Oxycontin and 30mg Oxycodone. There was no documented physical examination or laboratory studies and Respondent did not obtain past medical records to confirm the diagnoses or prescriptions; however, he prescribed her 40mg Oxycontin #90, 30mg Oxycodone #45, and Requip.

21. In October 2007, Respondent added Adderall to JF's medication regime without any rationale for the medication. During the course of treatment, JF reported on multiple occasions damaged or stolen prescriptions, running out of medication, and that the pharmacy had refused to fill a prescription because of different handwriting. Respondent continued to prescribe the medications and escalated the doses of Oxycodone and Adderall. There was no documentation that Respondent ordered any

laboratory studies to support his continued prescribing of Oxycodone, Oxycontin, and Adderall or any urine drug screens to determine whether JF was taking the medications as prescribed and/or illicit substances. In addition, there was no documentation that Respondent referred JF to a specialist for a consultation.

22. The standard of care requires a psychiatrist to perform adequate psychiatric evaluations.

23. Respondent deviated from the standard of care because he did not perform an adequate psychiatric evaluation for JF.

24. The standard of care when prescribing Adderall requires a physician to perform tests to confirm the diagnosis and the necessity of the medication and to monitor the patient's use of the medication.

25. Respondent deviated from the standard of care because he did not perform tests to confirm the diagnosis and the necessity of the medication and he did not monitor JF's use of the medication.

26. The standard of care when prescribing opioids for the treatment of chronic pain requires a physician to review previous diagnostic studies and interventions, assess the chronic pain complaint prior to initiating an opioid trial, appropriately monitor the patient's use of the medication, and obtain appropriate therapeutic and laboratory test results that support the diagnosis.

27. Respondent deviated from the standard of care because he did not review past medical records and he did not order appropriate tests or consultations for JF.

28. There was no collateral information to support prescribing Adderall creating a potential for misdiagnosis, addiction, abuse, misuse, overdose, and diversion. Since no urine drug tests were performed it is unknown whether JF was taking the medication as prescribed and/or whether she was utilizing illicit substances.

29. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did not obtain JF's past medical records, he did not document a physical examination prior to prescribing medications and he did not document any rationale for prescriptions, dosage escalations, and additions of medication. Additionally, Respondent used non-standard abbreviations.

PATIENTS DD, SS, AM, and MF

30. In 2008, Respondent treated patients DD, SS, AM, and MF for chronic pain. Respondent prescribed various medications that included Oxycodone and Oxycontin based on the patients' reported history and complaints of chronic pain. There was no documentation that Respondent obtained the patients' past medical records to confirm the diagnoses. During his course of treatment, Respondent provided early refills and escalated the patients' doses of Oxycodone and Oxycontin without documenting a rationale to support his diagnosis or prescribing. Specifically, he did not perform adequate physical examinations, obtain past medical records, or order diagnostic and laboratory studies.

31. There also was no documentation that Respondent ordered laboratory studies or referred the patients to a specialist to confirm his continued prescribing of the opioids. In addition, there was no documentation that Respondent performed any urine drug screens to determine whether the patients were taking the medications as prescribed and/or illicit substances.

32. The standard of care when prescribing opioids for the treatment of chronic pain requires a physician to review past diagnostic studies and interventions, assess and confirm the chronic pain complaint prior to initiating an opioid trial, appropriately monitor the patient's use of the medication, and obtain appropriate therapeutic and laboratory results that support the diagnosis.

33. Respondent deviated from the standard of care because he did not review DD's, SS's, AM's, and MF's past diagnostic studies and interventions, assess and confirm their chronic pain complaints prior to initiating an opioid trial, appropriately monitor their use of the medication, or obtain appropriate therapeutic and laboratory results to support his diagnoses of chronic pain.

34. There was no collateral information to support prescribing opioids to DD, SS, AM, and MF creating a potential for misdiagnosis, addiction, abuse, misuse, overdose, and diversion. Since no urine drug tests were performed it is unknown whether DD, SS, AM, and MF were taking the medication as prescribed and/or whether they were utilizing illicit substances.

35. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did not obtain DD's, SS's, AM's, and MF's past medical records; he did not document adequate physical examinations or laboratory and diagnostic studies prior to prescribing medications; he did not obtain any diagnostic studies to support his continued prescribing

of medications and he did not document any rationale for prescriptions and dosage escalations.

MD-09-0250A

PATIENT ML

36. The Board initiated case number MD-09-0250A after receiving a complaint regarding Respondent's care and treatment of a twenty-three year-old male patient ("ML").

37. ML established care with Respondent in October 2006. Respondent diagnosed ML with spondylolisthesis based on his reported history and prescribed Oxycodone. Respondent did not perform a facet, sacroiliac joint, myofascial pain, or neural flexes examination and he did not test ML for weakness or numbness. Respondent also did not order flexion extension films to assess spinal instability from spondylolisthesis or a magnetic resonance imaging scan to assess for neural compression. In November 2007, Respondent documented that ML, on his own, increased the Oxycodone medication; however, there was no documentation that Respondent cautioned ML to adhere to the prescribing instructions.

38. From January through December 2007, Respondent prescribed multiple early refills of Oxycodone. In January 2007, Respondent added Hydrocodone to ML's medication regime, but discontinued it in March 2007 without indication. From February 2008 through December 2008, Respondent continued to prescribe Oxycodone with multiple early refills. In June 2008, Respondent was notified that ML was undergoing Methadone treatment at a facility; however, Respondent did not obtain ML's medical records from the facility.

39. In January 2009, Respondent discharged ML from opioid therapy, but in March 2009, he restarted the opioids without explanation. Additionally, during the course of Respondent's treatment and care of ML, there was no further documentation that

Respondent performed any examinations prior to prescribing the medications. There also was no documentation that Respondent obtained ML's past medical records or diagnostic studies.

40. The standard of care prior to initiating high dose opiate therapy requires a physician to perform an adequate exam for pain generators.

41. Respondent deviated from the standard of care because he did not perform an adequate exam prior to initiating high dose opiate therapy.

42. The standard of care requires a physician to obtain the patient's past medical records and diagnostic studies.

43. Respondent deviated from the standard of care because he did not obtain ML's past medical records and diagnostic studies.

44. The standard of care requires a physician to offer the patient adjunct treatments that include non-opioid medications and physical therapy.

45. Respondent deviated from the standard of care because he did not offer adjunct treatments.

46. The standard of care requires a physician to address aberrant drug seeking behaviors and to refrain from prescribing more than one month of Schedule II prescriptions at a time.

47. Respondent deviated from the standard of care because he did not address ML's aberrant drug seeking behaviors, and he did not refrain from prescribing more than one month of Schedule II prescriptions at a time.

48. There was potential for diversion or abuse of the Oxycodone. Actual harm is not alleged.

49. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the

diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there was no documentation that Respondent performed any neuro and musculoskeletal examinations prior to prescribing opioid therapy, no documentation that Respondent cautioned ML to stay within the prescribing instructions, no documented rationale for re-starting opiates again later and Respondent did not obtain ML's medical records from the treatment facility or from his previous treating physicians.

MD-09-0926A

PATIENT WO

50. The Board initiated case number MD-09-0926A after receiving a complaint regarding Respondent's care and treatment of a fifty-two year-old male patient ("WO").

51. On January 14, 2008, Respondent assumed care and treatment of WO for his chronic pain syndrome. WO was on Oxycodone, Morphine Sulfate immediate release (MSIR) and Soma, which had been prescribed by his previous physician. Respondent reviewed previous imaging studies that included a computed tomography scan of WO's pelvis and abdomen that showed healed lower right lateral rib fractures, but no other abnormalities and a cervical spine film that showed mild hypertrophic degenerative changes in the mid cervical spine, but no other abnormalities. From the initial visit until July 27, 2009, Respondent continued to see WO and refill his prescriptions from his previous treating physicians. There was no documentation that Respondent performed a neurological or musculoskeletal examination or ordered any imaging studies of WO's lumbar spine or laboratory studies prior to continuing the treatment of WO's previous treating physician.

52. From March 2008 through December 2008, Respondent increased WO's 30mg of Oxycodone to six tablets per day. On May 30, 2008, Respondent added Morphine Sulfate (MS) Contin 30mg for poor sleep, but subsequently increased the dose without documenting a rationale for the increase. There was no documentation that Respondent performed any physical examinations or obtained any radiologic studies to support his increased opioid prescribing.

53. On February 6, 2009, Respondent discontinued prescribing MS Contin and instead prescribed a dose of 30mg of morphine sulfate, six tablets per day. Simultaneously, Respondent increased WO's Oxycodone dose to eight tablets per day without documenting a rationale for the increase.

54. On March 10, 2009, Respondent obtained a urine drug screen for WO, which was negative for Oxycodone; however, the drug screen was positive for Methadone and Codeine, which were not among his prescribed medications, and heroin. At the next visit, Respondent documented that he was aware of the positive drug screens; however, he did not adequately investigate or address the abnormal results, which include referring WO to an addiction medicine specialist or discontinuing the opioid prescriptions.

55. The standard of care requires a physician to perform an adequate work up of the patient prior to continuing treatment of the patient's prior treating physician.

56. Respondent deviated from the standard of care because he did not perform an adequate work up of WO prior to continuing the treatment of his previous treating physician.

57. The standard of care requires a physician to perform an adequate physical examination and obtain radiologic data to support the amount of opioid medications prescribed to the patient.

58. Respondent deviated from the standard of care because the physical examination and radiologic data did not support the amount of opioid medications he prescribed to WO.

59. The standard of care requires a physician to adequately investigate or address the patient's abnormal urine drug screens.

60. Respondent deviated from the standard of care because he did not adequately investigate or address WO's abnormal urine drug screens.

61. Respondent allowed WO to continue a pattern of illicit substance use and opioid misuse. The long-term use of Soma has the potential for habituation and misuse. Respondent's prescribing of 240 tablets of Oxycodone per month created a potential for misuse and diversion. Actual harm is not alleged.

62. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there was no documentation that Respondent performed a neurological or musculoskeletal examination or ordered any imaging or laboratory studies prior to continuing the treatment and there was no documented rationale for his excessive prescribing of opioids.

CHART REVIEWS

MD-09-1263A

63. Respondent received a Letter of Reprimand and was placed on probation by the Board on April 1, 2009. Respondent successfully completed and met all requirements of that probation and was formally discharged from the probation. As a term of the

probation, Respondent was to participate in the periodic review of his patients' charts. Three patient charts were randomly selected by Board staff and reviewed by a medical consultant who found deviations from the standard of care in each case. The medical consultant also noted medical recordkeeping issues.

PATIENT JR

64. JR was treated by Respondent for reported neck and back pain from July 3, 2007 until on or about September 21, 2009. No previous medical records were obtained prior to Respondent prescribing Oxycodone along with Xanax and Subutex. Although CT scans of the head and neck were reported normal on 2/18/08, Respondent continued to prescribe Oxycodone on numerous occasions until on or about August 7, 2009. Respondent changed JR's medication on several occasions without documenting his reasoning and Respondent refilled JR's medication after JR reported that it had been stolen.

65. The standard of care when treating a patient for chronic pain is to obtain prior records pertaining to the past treatment of the patient.

66. Respondent deviated from the standard of care because he did not obtain JR's previous medical and/or treatment records prior to prescribing opioid medication for reported chronic pain.

67. The standard of care when treating a patient for chronic pain is to obtain any objective measures for the cause of the pain.

68. Respondent deviated from the standard of care because he failed to obtain objective measures for the cause of JR's pain.

69. Respondent's conduct could result in an overdose and/or perpetuation of drug seeking behavior and addiction. Actual harm is not alleged.

70. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records are inadequate because they fail to document a treatment plan and reasoning for high dose opioids in a patient with a history of substance abuse, lost/stolen medications and positive drug screen findings. Further, Respondent's records failed to adequately document the reasoning and results regarding the prescribing of Adderall.

PATIENT LP

71. LP presented to Respondent on August 23, 2005 with a reported history of chronic lower back pain, DJD, musculoskeletal pain, chronic depression, PTSD, Lupus and ADD. On that date and subsequently, Respondent prescribed the opioids, Oxycontin and Oxycodone without obtaining past medical records. Objective data in the chart, such as x-rays, were documented as normal; however, Respondent continued to treat LP with opioids and/or methadone through on or about October 27, 2009 without a documented treatment plan. Medications were increased and/or changed at times without documented reasoning.

72. The standard of care when treating a patient for chronic pain is to obtain objective measures as to the cause of the pain.

73. Respondent deviated from the standard of care in that he continued to treat LP's reported pain with high-dose opioid medications without obtaining objective measures as to the cause of the reported pain.

74. Respondent's conduct could result in an overdose or perpetuation of drug seeking behavior and addiction. Actual harm is not alleged.

75. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records are inadequate because they fail to adequately document the initial visit, treatment plan and reasoning for high dose opioids and changes in medications.

PATIENT ML

76. Patient ML is the same patient who is the subject of paragraphs 36 through 49 above. After being placed on probation by the Board, Respondent continued to prescribe pain medication to ML until on or about September 14, 2009.

77. Respondent continued to prescribe high-dose opioids to ML for pain secondary to spondylolisthesis, although, an x-ray in the chart dated February 18, 2008, states "no evidence of spondylolisthesis."

78. The standard of care when treating a patient for chronic pain is to obtain objective measures as to the cause of the pain.

79. Respondent continued to treat ML's reported pain with high-dose opioids without obtaining objective measures for the cause of his pain.

80. Respondent's conduct could result in perpetuation of ML's drug seeking behavior/addiction or an overdose. Actual harm is not alleged.

MD-10-0100A

81. The Board initiated case number MD-10-0100A after receiving a Complaint from a pharmacy at UPH alleging inappropriate prescribing.

82. Respondent prescribed large amounts of opioids to patient CJ with an inadequate treatment plan; although, CJ had a history of testing positive for Heroine, Oxycodone, Morphine and Cocaine. On two occasions, CJ tested positive for narcotics that were not prescribed by Respondent.

83. The standard of care is to develop an adequate treatment plan prior to prescribing opioids and to treat the patient's substance abuse problem before treating pain.

84. Respondent prescribed opioids to CJ without an adequate treatment plan.

85. Respondent's conduct exposed the patient to possible drug overdose and drug diversion. Actual harm is not alleged.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

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2. Practice Restriction

a. Respondent is prohibited from prescribing, administering or dispensing any opioids for a period of **one year**; however, Respondent is given 60 days from the effective date of this Order to terminate opiate care of all of his patients requiring opioids such that the patients have the opportunity to find another provider.

b. **The one-year restriction will commence upon the conclusion of the 60-day period in which Respondent is to terminate opiate care of patients requiring opioids.**

3. Probation

Respondent is placed on probation for **two years** with the following terms and conditions:

a. Respondent shall, within 30 days of the effective date of this Order, enter into a contract with Affiliated Monitors to provide all monitoring services. Respondent shall pay all costs of monitoring requirements and services.

b. Respondent is to complete the PACE prescribing course within 6 months of the effective date of this Order.

c. Upon completion of the PACE prescribing course, Affiliated Monitors will conduct quarterly chart reviews for the remainder of the probationary period and report results to the Board. Respondent shall pay the expenses of Affiliated Monitors and all chart reviews and fully cooperate with any requests made by Affiliated Monitors in conducting the chart reviews.

d. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

e. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

4. This Order is the final disposition of case numbers MD-09-0131A and MD-09-0250A, MD-09-0926A, MD-09-1263A and MD-10-0100A. Moreover, it is agreed that there will be no further charges brought against Respondent arising out of past or current patient charts that the Board has taken possession of to date.

DATED AND EFFECTIVE this 10th day of June, 2010.

ARIZONA MEDICAL BOARD

(SEAL)

By Amanda Dick
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent consents to the entry of the order set forth above as a compromise of a disputed matter between Respondent and the Board, and does so only for the purpose of terminating the disputed matter by agreement. Respondent acknowledges it is the Board's position that, if this matter proceeded to formal hearing, the Board could establish sufficient evidence to support a conclusion that certain aspects of Respondent's conduct constituted unprofessional conduct.

2. Respondent agrees not to contest the validity of the Findings of Fact and Conclusions of Law contained in the Order in any present or future administrative proceedings before the Board (or any other state agency in the State of Arizona, concerning the denial or issuance of any license or registration required by the state to engage in the practice or any business or profession.)

3. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

4. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

5. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

6. The Order is not effective until approved by the Board and signed by its Executive Director.

7. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving

the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

8. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

9. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

10. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

11. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

12. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. §§ 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

13. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot act as a supervising physician for a physician assistant while his license is under restriction.

14. ***Respondent has read and understands the conditions of the restriction.***

DAVID A. RUBEN, M.D.

DATED: 5-20-10

APPROVED AS TO FORM BY:

THOMAS A. ZLAKET
ATTORNEY FOR RESPONDENT

DATED: 5/21/10

ORIGINAL of the foregoing filed this 10th day of June, 2010 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 10th day of June, 2010 to:

Thomas A. Zlaket, Esq.
Thomas A. Zlaket, P.L.L.C.
310 S. Williams Blvd., Suite 170
Tucson, Arizona 85711-4446

EXECUTED COPY of the foregoing mailed this 10th day of June, 2010 to:

David A. Ruben, M.D.
Address of Record

Investigational Review
#834668